



**STATE OF TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY**

500 Deaderick Street, Suite 850
Nashville, TN 37243
615/741-2364

**REPORT OF INTENT TO ALTER EXISTING BED CAPACITY
HOSPITAL**

INSTRUCTIONS: This form must be filed in **triplicate** with the Health Services and Development Agency prior to the hospital's request for review by the Board for Licensing Health Care Facilities. **NOTE:** Public Chapter 780, Acts of 2002 permits a hospital with fewer than one hundred (100) licensed beds to increase to total number of licensed beds by ten (10) beds over any period of one (1) year without obtaining a certificate of need. If you wish to pursue this exemption, please complete this form.

1. NAME AND ADDRESS OF FACILITY

(Name)

(Street Address)

(County)

(Mailing Address, if different from Street Address)

(City)

(State)

(Zip)

(Telephone Number)

2. NAME AND ADDRESS OF OWNER OF FACILITY

(Name)

(Street Address)

(City)

(State)

(Zip)

(Telephone Number)

3. CONTACT PERSON OR AUTHORIZED AGENT

(Name)

(Title)

(Company)

(E-mail Address)

(Mailing Address)

(Telephone Number)

(City)

(State)

(Zip)

(Fax Number)

4. BRIEF DESCRIPTION OF PROJECT

5. BED COMPLEMENT DATA

Current Licensed Beds	Bed Change Proposed	Total Beds after Completion
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6. PROJECTED COMPLETION DATE

Have you added beds under this exemption previously?	Yes	No
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I hereby certify that this information is true to the best of my knowledge, information, and belief, and that supplemental written notification will be filed with the Tennessee Health Services and Development Agency in the event of any change in the information given in this report.

Signature

Date